RURAL DISTRICT OF DAVENTRY

ANNUAL REPORT

of the

MEDICAL OFFICER OF HEALTH

FOR THE YEAR 1972

JOAN M. ST. V. DAWKINS

Medical Officer of Health

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DAVENTRY RURAL DISTRICT COUNCIL

Members of the Public Health and Housing Committees:-

Chairman of Public Health Committee: Mr. Councillor A.J. Checkley
Chairman of Housing Committee: Mr. Councillor C.H. Shingles

Vice Chairman of Public Health Committee: Mr.Councillor H.Seal
Vice Chairman of Housing Committee: Mrs.Councillor G.L.Atterbury

Messrs. Councillors E.R.Buswell. (Chairman of the Council); J.Cox (Vice Chairman of the Council); J.O.Adams, J.P. T.C.Bodily; Miss.N.A.Burrows; Mrs.F.E.Chaplin; Mrs.P.A.Dent; F.J.Dixon; W.H.Eadon; Mrs.M.H.Henson; Mr.J.R.Hutt; Mrs.J.M.Jackson; A.B. Lees; Mrs.N.Leach; H.A.Malin; S.J.Patrick; Rev. Canon S.F.W.Powell; W.J.Preece; R.Quinney; V.J.Smith; H.E.Upton and Mrs.C.D.Woodroffe.

Public Health Officers of the Council.

Joan M. St V. Dawkins, M.B., B.S., F.F.C.M., D.P.H., D.C.H.,

Medical Officer of Health, Division 1, Northamptonshire.

(Boroughs of Brackley and Daventry; Urban District of Wellingborough; Rural District of Brackley, Brixworth, Daventry, Northampton, Towcester and Wellingborough.)

Senior Assistant County Medical Officer of Health

Secretary: Mrs. Erica Stevenson

Chief Public Health Inspector and Housing Officer:
B.K.L. Doughty. M.A.P.H.I., M.Inst.P.C.

Additional Public Health Inspector
S.J. Green. M.A.P.H.I.

Public Health Inspector's Assistant and Meat Inspector
B.C.Lines. A.M.R.S.H. M.A.M.I.

To: The Chairman and Members of the Rural District Council of Daventry.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my seventeenth Annual Report as Medical Officer of Health, which also incorporates that of the Chief Public Health Inspector.

The report is presented once again in six sections, each dealing with an aspect of the control of the environmental health of the area.

The vital statistics for the year show that there was an increase in population of 240 according to the Registrar General's mid-year estimate of 18,990. There were 210 deaths, a decrease of 5 on last year's figure. This gives a standardised rate of 11.3 compared with the national figure of 12.1. The total number of live births was 283, a decrease of 13 on last year and giving a standardised rate of 16.1, compared with the national figure of 14.8. Illegitimate births were 17, 1 more than in 1971. There were 5 deaths under the age of one year, four occurring in the first week of life.

The first section (A) dealing with natural and social conditions indicates that the rural atmosphere of the district remains virtually unchanged with little industry and agriculture continuing as the main occupation. In this section statistics of births and deaths are given, and consideration made of the causes of early and preventable morbidity and death. While the annual report relates to local environmental health it would be incomplete without some reference to the personal health of individuals living in the area. The section includes comments on cancer, arterial disease, a study on road accidents and details of a ROSPA report on home accidents.

The second section (B) outlines health and social services, both statutory and voluntary, which are provided in the district. Services given, particularly to the elderly, on a voluntary basis make a valuable contribution to the community life, and gratitude to those who give so unstintingly of this constant help is expressed.

The third section (C) deals with sanitary circumstances giving a description of water supplies, sewerage, refuse collection and disposal, rodent control, offices and shops and other health functions. The new sewerage scheme at Whilton was completed during the year, and alterations at Braunston together with progress on the Staverton and Hellidon scheme took place. Plans for the Long Buckby regional scheme were also submitted for approval. Future environmental health control, after reorganisation of services, is also considered.

The fourth section (D) is concerned with council housing, giving an account of slum clearance, (999 unfit houses have been cleared, while 250 remain), council house tenancies, improvement grants and other matters. The Chief Public Health Inspector of this authority is also the housing manager, and is responsible for the organisation of council house allocation. In 1972 no council houses were built. 167 houses were provided by private enterprise.

The fifth section (E) deals with food hygiene, which continues to be a major concern of health departments. Changes due to technical advances in the food industry, while greatly improving variety and keeping quality, do not lessen, but rather increase the need for vigilance in food control. Innovations in manufacture, storage and cooking, together with increasing mobility of the popu-

lation (including travel abroad and the importation of infections), demand constant control. The ultimate responsibility, however, always remains with the actual food handlers, and the rapid turnover of employment, together with these other factors require supervision from both employer and inspector. Finally consumers, themselves on the alert, should refuse to accept unsatisfactory practices.

The sixth section (F) deals with control of infectious and other diseases in the district, and it is pleasing to record that there were no cases of dysentery, only three isolated cases of food poisoning and two of infective hepatitis. 14 people died from pneumonia and 3 from bronchitis. There were 38 cases of measles compared with 84 in 1971. Measles vaccination increased considerably in the country. It is to be hoped that from henceforward, with the availability of vaccines and the use of the computer, that a higher percentage of children will be vaccinated. While at present the incidence of infectious illness remains satisfactorily low, should succeeding generations of parents fail to respond to the need for immunisation, recrudescence could occur. It remains vitally important therefore for children to be immunised for diphtheria, poliomyelitis, whooping cough, tetanus and now measles, tuberculosis vaccination following later in the early teens. Rubella (German Measles) vaccination is also available to all girls between the ages of eleven and fourteen.

The year was notable for the proposed legislation for the reorganisation of Local Government, the National Health Service, and the Water Authorities, which are timed to coincide in April 1974. The office of Medical Officer of Health will cease, and instead those at present practicing in the public health field will join the National Health Service as part of the new discipline of community medicine. Local authorities will no longer employ doctors, but medical advice will be obtained from community physicians. As the envisaged changes are of historic importance I have attached to this report an appendix which outlines the future role of the community physician and gives some detail of the structure of the reorganised National Health Service, considering also a little of the perspective of the changes in health legislation during the century of the practice of public health.

While this report will be my last to this council, and the penultimate one on the health of the district (which will be presented to the enlarged District Council in 1974) I considered it appropriate to present this detailed account of the changes, and at the same time to express the hope, that with adequate collaboration arrangements the future medical advice which will be available to local authorities will be both sought and given as freely and with the same accessibility between doctor, officers and councils of local authorities as when the Medical Officer of Health held office as a statutory appointment.

On a personal note I had the honour to hold office as Chairman of the Northampton division of the British Medical Association; was appointed Chairman of the Oxford Region of Public Health Medical Officers for the fifth year, and represented that Region, again for the fifth year on the Public Health Committee of the British Medical Association. I was also again appointed to the Whitley Council Staff Side.

I would like to pay my tribute to the council who have always sought high standards in public health and shown interest in the preventive health field. I give thanks for the personal kindness and

co-operation I have received from councillors and officers. To my colleagues the public health inspectors, I express the wish that the long, cordial and successful association already established will be maintained in the same happy vein under reorganisation.

Finall I express my appreciation to the County Medical Officer of Health for his ready co-operation at all times.

I have the honour to be your
Obedient Servant,

JOAN M. ST. V. DAWKINS
Medical Officer of Health.

Council Offices,
Church Walk,
DAVENTRY, NN11 4BJ. Tel: 2184-5-6

SUMMARY OF VITAL STATISTICS FOR 1972

Area (in acres)	79,424
Population (mid-year estimate by Registrar General)	18,990
Number of separate dwellings occupied	7,113
Number of caravans occupied	8
Rateable Value (1st April 1973)	£1,953,566.00
Product of a 1p. rate	£18,861.00

NORTHAMPTONSHIRE COUNTY COUNCIL

Vital Statistics:

Population 1972 mid-year estimate 351,000

	Northamptonshire				England and Wales
	Males	Females	Total	Rate	(Total) Rate
Live Births	3,003	2,946	5,949		
Live Birth rate per 1,000 Population.				16.95	14.79
Illegitimate live births per cent of total live births				7.1	8.6
Stillbirths	24	26	50		
Stillbirths rate per 1,000 live and Stillbirths...				8.33	11.9
Total live and stillbirths	3,027	2,972	5,999		
Infant Deaths	59	40	99		
Infant Mortality Rate: Total (per 1,000 live births)				16.64	17.22
Legitimate (per 1,000 legitimate live births) ...				16.28	
Illegitimate (per 1,000 illegitimate live births)				16.86	
Neonatal (first four weeks) mortality rate per 1,000 live births				10.59	11.54
Early Neonatal (under 1 week) mortality rate per 1,000 live births				9.41	9.85
Perinatal (stillbirths and deaths, under 1 week combined) mortality rate per 1,000 live and stillbirths. ...				17.82	21.97
Maternal deaths (including abortions)				1	
Maternal mortality rate per 1,000 live and stillbirths.				0.17	

SUMMARY OF VITAL STATISTICS SINCE 1948

		BIRTHS		DEATHS			
	Estimated		Crude	Under 1 year		All ages	
Year	Population	No.	Rate	No.	Rate	No.	Rate
1948	15,850	281	17.6	6	21.0	167	10.60
1949	15,900	250	15.7	14	56.0	217	16.10
1950	15,840	255	16.0	5	19.6	190	11.90
1951	16,290	274	16.9	4	14.6	201	12.30
1952	16,440	236	14.3	7	29.6	182	11.07
1953	16,480	252	15.29	7	27.7	162	9.83
1954	16,590	257	15.27	2	7.7	202	12.1
1955	16,550	222	13.3	5	22.5	185	11.21
1956	16,490	265	16.09	5	22.5	185	11.21
1957	16,450	269	16.35	5	18.58	197	11.97
1958	16,370	267	16.3	9	33.7	196	11.36
1959	16,480	248	15.05	3	11.8	185	11.2
1960	16,190	251	15.5	5	19.9	188	11.6
1961	15,830	249	15.7	2	8.0	186	11.7
1962	16,050	276	17.9	2	7.2	188	11.09
1963	16,520	306	18.52	4	12.8	202	12.23
1964	17,050	299	17.53	5	16.7	181	10.61
1965	17,580	291	16.5	5	17.1	181	10.3
1966	17,940	345	19.2	5	14.4	205	11.4
1967	18,160	291	16.0	2	6.9	198	10.9
1968	18,430	310	16.8	5	16.1	222	12.0
1969	19,150	288	15.0	3	10.0	221	11.8
1970	19,350	275	14.2	9	33.0	224	11.9
1971	18,750	296	19.6	-	-	215	11.8
1972	18,990	285	16.1	5	18.0	210	11.3

Vital Statistics

		Local Authority Area. Males	Females	Total	England and Wales (Total)
Estimated mid-year home population		-	-	18,990	49,028,900
Live Births	Total	138	145	283	725,405
	Legitimate	129	137	266	662,907
	Illegitimate	9	8	17	62,498
Stillbirths	Total	-	2	2	8,794
	Legitimate	-	2	2	7,846
	Illegitimate	-	-	-	948
Total live and still births.	Total	138	147	285	734,199
	Legitimate	129	139	268	670,753
	Illegitimate	9	8	17	63,446
Deaths of infants under 1 year of age.	Total	3	2	5	12,494
	Legitimate	3	2	5	11,177
	Illegitimate	-	-	-	1,317
under 4 weeks of age	Total	2	2	4	8,373
	Legitimate	2	2	4	7,503
	Illegitimate	-	-	-	870
under 1 week of age	Total	2	2	4	7,142
	Legitimate	2	2	4	6,365
	Illegitimate	-	-	-	777
Deaths all ages		105	105	210	591,907

	Local Authority Area.	England and Wales
Live birth rates etc.,		
Live births per 1,000 home population (Crude rate)	14.9	14.8
Area comparability factor	1.08	1.00
Local adjusted rate	16.1	14.8
Ratio of local adjusted rate to national rate.	1.09	1.00
Illegitimate live births as percentage of all live births.	6	9
Stillbirth rate:		
Stillbirths per 1,000 total live and stillbirths	7	12
Infant mortality rates:		
Deaths under 1 year per 1,000 live births	18	17
Deaths of legitimate infants under 1 year per 1,000 legitimate live births.	19	17
Deaths of illegitimate infants under 1 year per 1,000 illegitimate live births.	-	21
Neonatal mortality rate:		
Deaths under 4 weeks per 1,000 live births	14	12
Early Neonatal Mortality Rate:		
Deaths under 1 week per 1,000 total live births.	14	10
Perinatal mortality rate:		
Stillbirths and deaths under 1 week combined, per 1,000 total live and stillbirths.	21	22
Death Rates, etc - all ages		
Deaths per 1,000 home population (crude rate)	11.1	12.1
Area comparability factor	1.02	1.00
Local adjusted rate	11.3	12.1
Ratio of local adjusted rate to national rate	.94	1.00

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE DURING 1972

	Sex	All-Ages	Under 4 Weeks	4 Weeks & Under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 & Over
MALIGNANT NEOPLASM, BUCCAL CAVITY ETC.	M	1	-	-	-	-	-	-	-	-	1	-	-
	F	3	-	-	-	-	-	-	-	-	1	2	-
MALIGNANT NEOPLASM, STOMACH	M	3	-	-	-	-	-	-	-	-	2	-	1
	F	1	-	-	-	-	-	-	-	-	-	-	1
MALIGNANT NEOPLASM, INTESTINE	M	4	-	-	-	-	-	-	-	-	-	1	3
	F	4	-	-	-	-	-	-	-	-	-	-	4
MALIGNANT NEOPLASM, LUNG, BRONCHUS	M	9	-	-	-	-	-	-	-	-	1	7	1
	F	4	-	-	-	-	-	-	-	-	2	2	-
MALIGNANT NEOPLASM, BREAST	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	6	-	-	-	-	-	-	-	1	2	2	1
MALIGNANT NEOPLASM, UTERUS	F	1	-	-	-	-	-	-	-	-	-	1	-
MALIGNANT NEOPLASM, PROSTATE	M	3	-	-	-	-	-	-	-	-	1	-	2
OTHER MALIGNANT NEOPLASMS	M	1	-	-	-	-	-	-	1	-	-	-	-
	F	8	-	-	-	-	-	-	1	1	3	1	2
BENIGN AND UNSPECIFIED NEOPLASMS	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	1	-	-	-	-	-	-	-	-	-	1	-
OTHER ENDOCRINE ETC. DISEASES	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	2	-	-	-	1	-	-	-	-	-	-	1
MULTIPLE SCLEROSIS	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	1	-	-	-	-	-	-	-	1	-	-	-
OTHER DISEASES OF NERVOUS SYSTEM	M	1	-	-	-	1	-	-	-	-	-	-	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
CHRONIC RHEUMATIC HEART DISEASE	M	2	-	-	-	-	-	-	-	-	-	2	-
	F	2	-	-	-	-	-	-	-	-	1	1	-
HYPERTENSIVE DISEASE	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	1	-	-	-	-	-	-	-	-	-	-	1
ISCHAEMIC HEART DISEASE	M	37	-	-	-	-	-	-	-	1	7	9	20
	F	27	-	-	-	-	-	-	-	1	2	6	18
OTHER FORMS OF HEART DISEASE	M	2	-	-	-	-	-	-	-	-	-	1	1
	F	3	-	-	-	-	-	-	-	-	-	2	1
CEREBROVASCULAR DISEASE	M	6	-	-	-	-	-	-	-	-	1	-	5
	F	15	-	-	-	-	-	-	-	-	-	-	-

OTHER DISEASES OF CIRCULATORY SYSTEM	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	6	-	-	-	-	-	-	-	-	-	1	5
INFLUENZA	M	1	-	-	-	-	-	-	-	-	-	1	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
PNEUMONIA	M	5	-	-	-	-	-	-	-	1	-	1	3
	F	9	-	-	-	-	-	-	-	-	-	-	9
BRONCHITIS AND EMPHYSEMA	M	3	-	-	-	-	-	-	-	1	-	1	1
	F	-	-	-	-	-	-	-	-	-	-	-	-
OTHER DISEASE OF RESPIRATORY SYSTEM	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	2	-	-	-	-	-	-	-	-	1	-	1
PEPTIC ULCER	M	2	-	-	-	-	-	-	-	-	-	1	1
	F	-	-	-	-	-	-	-	-	-	-	-	-
APPENDICITIS	M	1	-	-	-	-	-	-	-	-	-	1	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
INTESTINAL OBSTRUCTION AND HERNIA	M	2	-	-	-	-	-	-	-	1	-	-	1
	F	1	1	-	-	-	-	-	-	-	-	-	-
OTHER DISEASES OF DIGESTIVE SYSTEM	M	1	-	-	-	-	-	-	-	-	1	-	-
	F	2	-	-	-	-	-	-	-	-	1	-	1
NEPHRITIS AND NEPHROSIS	M	1	-	-	-	-	-	-	-	-	-	1	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
HYPERPLASIA OF PROSTATE	M	2	-	-	-	-	-	-	-	-	-	-	2
OTHER DISEASES, GENITO-URINARY SYSTEM	M	2	-	-	-	-	1	-	-	-	-	-	1
	F	1	-	-	-	-	-	-	-	-	-	-	1
DISEASES OF MUSCULO-SKELETAL SYSTEM	M	-	-	-	-	-	-	-	-	-	-	-	-
	F	1	-	-	-	-	-	-	-	-	-	1	-
CONGENITAL ANOMALIES	M	2	1	-	-	-	-	1	-	-	-	-	-
	F	1	-	-	1	-	-	-	-	-	-	-	-
BIRTH INJURY, DIFFICULT LABOUR, ETC	M	2	1	1	-	-	-	-	-	-	-	-	-
	F	1	1	-	-	-	-	-	-	-	-	-	-
MOTOR VEHICLE ACCIDENTS	M	5	-	-	-	-	2	1	1	-	1	-	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
ALL OTHER ACCIDENTS	M	4	-	-	-	1	1	-	-	1	-	-	1
	F	2	-	-	-	-	-	-	-	-	-	-	2
SUICIDE AND SELF-INFLICTED INJURIES	M	2	-	-	-	-	1	-	1	-	-	-	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
ALL OTHER EXTERNAL CAUSES	M	1	-	-	-	-	-	-	-	-	-	1	-
	F	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL ALL CAUSES	M	105	2	1	-	2	5	2	3	5	15	27	43
	F	105	2	-	1	1	-	-	1	4	13	24	59

STATISTICS SHOWING POPULATION AND NUMBERS OF OCCUPIED HOUSES IN EACH PARISH OF THE DISTRICT.

	Population			Number of Occupied Houses		
Parish	1931 census	1951 census	1961 census	Private Houses	Council Houses	Total
Ashby St. Ledgers	210	196	142	55	-	55
Badby	440	478	483	147	66	213
Barby	471	536	427	262	44	306
Braunston	1015	1161	1198	355	185	540
Brockhall	38	34	29	8	-	8
Byfield	868	796	838	237	136	373
Canons Ashby	49	42	23	10	-	10
Catesby	91	85	80	29	-	29
Charwelton	165	166	157	41	8	49
Clay Coton	71	51	54	11	4	15
Crick	681	728	780	350	69	419
Dodford	238	216	162	51	5	56
Elkington	69	62	53	19	-	19
Everdon	406	420	364	123	24	147
Farthingstone	177	174	145	51	8	59
Fawsley	29	21	29	13	-	13
Flore	786	896	927	311	106	417
Hellidon	148	160	141	56	4	60
Kilsby	501	558	666	253	82	335
Lilbourne	209	241	227	83	29	112
Long Buckby	2325	2316	2368	792	221	1013
Newnham	356	383	358	140	32	172
Norton	315	265	243	122	-	122
Preston Capes	156	167	162	56	12	68
Stanford	53	43	36	12	-	12
Staverton	319	361	365	115	30	145
Stowe-ix-Churches	219	180	151	77	4	81
Watford	324	281	236	72	14	86
Weedon	1750	1734	1489	383	213	596
Welton	358	381	364	142	51	193
West Haddon	714	704	770	265	72	337
Whilton	216	168	171	58	10	68
Winwick	153	89	92	34	-	34
Woodford Halse	1740	1764	1775	436	206	642
Yelvertoft	349	462	451	247	46	293
	16009	16293	15956	5452	1681	7133

It will be noted that the mid-year population, 1972 estimated by the Registrar-General was 18,990.

SECTION A

NATURAL AND SOCIAL CONDITIONS.

The District continues to be largely rural, the main occupation being agriculture. However, the majority of the working population are employed outside the district at Daventry, Banbury, Coventry, Northampton or Rugby. There is a Ministry of Works and Public Buildings Depot and a Ministry of Transport Goods Vehicle testing station at Weedon, on the sites of the old Ordnance Factory and Equitation School, also a small chemical factory in that parish. At Welton the large Export Packing Station continues, but the factory producing pre-cast concrete building sections closed during the year. The light engineering factory which closed down the previous year, was re-opened in a very small way during the year, but its future was in some doubt. There are small light engineering factories at Braunston and Weedon, a small factory with additions was maintained at Barby. The glue and adhesive factory continued at Braunston. The potato crisp factory at Long Buckby flourished, whilst the small boot and shoe closing factories at Long Buckby, Weedon, Woodford Halse (2) created some measure of employment, particularly amongst the female members of the areas. The M1 motorway with its canteens and petrol filling stations on each side of the motorway at Watford Gap created employment for both male and female persons.

The area of the district is 79,424 acres or 124.3 square miles, which gives an average of one person to 4.2 acres or 151 persons to the square mile.

The Registrar-General's figure of the mid-year estimated population was 18,990 showing an increase of 240 on the figure for 1971, but probably this total had increased by the end of the year. The 1971 census figure for the district was 19,035. The natural increase in the population, the excess of births over deaths was 75.

BIRTHS: The number was 283, a decrease of 13 compared with the previous year giving a standardised rate of 16.1 calculated on the comparability factor of 1.08, compared with 14.8 for England and Wales per 1,000 of the total population.

STILLBIRTHS: The figure was 2, compared with 1 the previous year and gave a rate of 7.0 per 1,000 live and stillbirths.

ILLEGITIMATE BIRTHS: The number was 17, an increase of 1 compared with the previous year.

MATERNAL MORTALITY: No death was recorded.

INFANT MORTALITY: There were 5 deaths of a child under the age of one year, compared with none the previous year.

DEATHS: The total recorded was 210, a decrease compared with the previous year. The standardised death rate was 11.3 compared with 12.1 for England and Wales. The standardised death rate is calculated from the Registrar-General's comparability factor (1.02) which makes allowance for age and sex distribution of the population in different areas and is adjusted specifically to take into account the presence of any residential institutions in the area. There remain, though generally people are living longer a number of premature and preventable deaths. In the district last year out of a total of 210 deaths, 57 died before the age of 65 and a further 51 between 65 and 74, making a total of 108 deaths before the age of 75.

Therefore, more than half of the total deaths are still occurring before the three score years and ten(with the hopeful addition of an extra 5 years). More people live to achieve the extra years, but life span remains static. Of the deaths before 75, 62 were males and 46 females. Premature death is now caused mainly by accidents, arterial diseases and the cancers. There were 5 deaths from motor vehicle accidents, all males, 2 under 24, and 1, 25-34, 1, 35-44, 1,55-64. Of the total of 102 deaths from diseases of the heart and circulation, 10 males and 4 females died before 64; 12 males and 14 females between the ages of 65 and 74; 26 males and 36 females over 75 years. The cancers took a total of 45 deaths, 4 of these before the age of 55, 12 between the age group 55-64; 16 the age group 65-74 and 13 the age group over 75 years. 9 males and 4 females died from cancer of the lung, 1 male,2 females 55-64, 7 males and 2 females 65-74 and 1 male over 75 years.

EARLY AND PREVENTABLE DEATH AND MORBIDITY.

DEATHS FROM CANCER

Lung Cancer and Cigarette Smoking.

It is probable that cigarette smoking is the greatest contemporary health problem. 50,000 deaths a year can be attributed to the habit It is responsible for 9 out of 10 deaths from ling cancer (of which there were in 1972 31,649, 25,649 males, 5,895 females), 3 out of 4 deaths from chronic bronchitis and 1 out of 4 deaths from coronary artery disease. It is estimated that twenty times more work days are lost through sickness from smoking than on industrial disputes.

The adverse effects on health of smoking unfortunately only become manifest after many years, and are therefore not obviously connected with the habit. Also in many countries as the economic benefits from legislation, and it is not practicable to impose regulations on an unwilling population. However it is imperative to take action that will discourage young people from starting to smoke, and may promote reduction or abstinence in smokers. This includes keeping people constantly and fully informed abouth the health consequences of smoking and pressing for the curtailing of all forms of sales promotion that encourage the use of tobacco.

It has been suggested in a published paper* that the most important approaches to combat the health hazards of smoking are as follows:-

1. The education of youth not to take up smoking.
   (In this respect all those adults who are associated with and have influence over young people should by the force of their own example discourage them from starting to smoke. These include parents, teachers, youth leaders, sportsmen, actors, pop stars and others whom young people admire and may emulate).

2. The exerting of the influence of health workers.
   (The medical profession have recognised the hazard, and now only a quarter of British male doctors smoke. Their death rate from lung cancer is now only 2/5th of the national figure).

3. Group approaches to the control of cigarette smoking by adults.
4. Mass approaches to the control of cigarette smoking.
5. Reducing the effectiveness of the advertising and promotion of cigarettes.
6. Less hazardous smoking

Other Cancers

The causes of cancer, apart from cancer of the lung, remain still to be ascertained. However some progress is being made, and different methods of controlling the cancerous diseases have greatly increased in effectiveness in recent years. Research is providing information which will help in prevention, in early detection and treatment. New techniques for detection including mammography and xerography, cytology and immunodiagnosis are being used and further improved, while chemotherapy with carcinostatic drugs and hormones and perhaps immunotherapy in the future, may all prove to be new and effective chemo-therapeutic agents. At present early detection and new and more effective treatment have restored numerous patients to lives of good quality for many years.

ARTERIAL DISEASE

The incidence of early degenerative arterial disease, particularly in men, has become the epidemic of civilisation, and presents with cancer, the major challenge to medicine today. The condition is manifest in either strokes or coronary thrombosis, and strikes men in their prime and at the time of their greatest contribution to society. The causes are multiple, and, as stated, cigarette smoking is probably a factor. As well as being part of the process of ageing hereditary factors are involved in some. Women are less affected until after the menopause, indicating a hormonal protection. The only clear evidence is that the incidence is lower in those who take regular physical exercise and who are not obese. This salient feature needs emphasis, as it is easy in a modern industrialised society with the majority occupied in sedentary occupations, the widespread use of motor transport and television, for many to become physically inactive. It is wise to establish a way of life soon after leaving school in which there is regular participation in physical exercise which can be suitably modified to the passing years. This combined with some moderation in the consumption of food, may help to prevent the early onset of arterial disease.

*Smoking and Health by Professor C.M. Fletcher & Dr.D. Horn. WHO Publication.

ACCIDENTS

Road Accidents

Definitions

A road accident is one involving personal injury, occurring on the public highway (including footpaths) in which a vehicle is concerned.

Killed means the person died at the time of injury or within 30 days of the accident and because of it.

The various degrees of injury to a person depend upon the extent of the injury requiring hospital in-patient treatment and may be:-

(i) Serious - such as fractures, internal injuries, severe shock, etc.,

(ii) Slight - sprains, cuts and bruises.

Vehicles involved in accidents are those whose drivers or passengers are injured and vehicles which contribute to the accident, including horses being ridden at the time of the accident. Vehicles which collide after the initial impact are not included unless they aggravate the degree or amount of injury. Vehicles are classified according to their structural type:-

(i) Pedal Cycles - include children riding toy cycles and first riders of tandems (they make the decisions).

(ii) Mopeds - two-wheeled motor vehicles of not more than 50 c.c. and equipped with pedals.

(iii) Motor Scooters- two wheels with a platform for feet, open frame and wheels smaller than the conventional motor cycle.

(iv) Motor Cycles - again with two wheels and includes side-car/combinations attached.

(v) Cars, taxis (including minibus), goods vehicles, public service vehicles and electric milk floats.

Incidence

In 1972 359,792 were killed or injured on Britain's roads, an increase of 2% on 1971. Broken down this shows:-

7,779 killed - 1% more than in 1971
91,342 seriously injured - no significant change
260,671 slightly injured - 3% more than in 1971

Motor traffic was estimated as 5% higher than in 1971 (measured in terms of vehicle mileage).

The number of accidents is related to the amount of traffic. The doubling of road casualties over the past 20 years is related to the fact that during this time road traffic has TREBLED. When considered in respect of population the trend has been far less happy as road deaths have increased by 57% while population increase was 10%. The individual risk has now increased from 150-1 to 100-1. Recent years have shown a growing proportion of casualties in the younger age groups:-

1:190 of 15-19 years killed each year
1:790 of 40-49 " " " "
1:725 of 60-69 " " " "

The incidence in the younger age groups therefore constitutes 33⅓% of car driver casualties and 45% were riders or passengers of motor vehicles. The 40-49 age group were occupants, drivers and passengers, in cars (⅔ of total), and 60-69 were (four wheel occupants) mostly as passengers in cars/buses.

Road Accidents involving Pedestrians

Pedestrians - including children (under 15 years) and adults - are children riding small cycles, people pushing bicycles or prams or other vehicles such as road sweepers, those leading or herding animals, occupants of invalid chairs or prams, and those who alight from vehicles and are subsequently injured or killed. The figures of accidents to children cause particular concern. One pedestrian in ten killed or seriously injured is aged four or less (for the first eighteen months of life they do not form part of the pedestrian population) indicating that nearly half the casualties are children.

The 60-69 group (elderly) suffer more than double the 40-49 years group. Compared with Western Europe, Britain has the highest pedestrian casualty rate, but for fatalities the figure is nearer the average. This factor is due to a great extent to the large number of pedestrians and the heavy traffic of built-up areas.

Causes of Accidents

1. Drinking alcohol to the extent of blurring judgement.
2. Not fastening seat belts when available.
3. Delaying repairs to vehicles and not performing routine checks on tyres, lights and brakes.
4. Driving too fast for road conditions - surface, lighting, type of area (30 mph), ice on roads, flooding, and in the summer, polished road surfaces and skidding.
5. Leaving off lights well into the lighting-up time (half-an-hour after sunset and half-an-hour before sunrise). The accident rate is higher during the hours of darkness.
6. Getting impatient or starting a journey in a "bad temper".
7. Certain manoeuvres cause or contribute to accidents - e.g. turning right (particularly pedal cyclists - cause of 17% of these accidents). Indicating the opposite direction to that intended to take: brake or acceleration failure; badly parked and unlit vehicles, dog or other animal in the path of the vehicle; automatic level crossings; a disobeyed junction control- a junction being any place at which two or more highways meet at whatever angle, including a roundabout parts of such highways within 20 yards of the junction.

Action taken to improve Accident Rate

1934 - Road Traffic Act, introduced driving tests, 30 mph speed limit and pedestrian crossings.

1952 - There was a further reduction in accidents following the introduction of zebra stripes on crossings.

1964 - Seat belts for the front seats of motor cars were introduced and to encourage greater use all new cars registered after 1st April 1973 are required to have the latest design of seat belts available which can be fitted and fastened single handed.

1967 - Road Safety Acts, drinking and driving clauses stated for the first time that a person driving a motor vehicle would be guilty of an offence if he was shown to have a blood alcohol content above a presribed level, that chosen being 80 mgm alcohol per 100 ml. blood. There was an immediate and remarkable drop in the accident rate following this legislation and the Act was continuing to have a marked affect at the end of 1972.

1971 - The department put forward proposals to make the wearing of safety helmets for motor cyclists compulsory (this is now law) and has been shown to represent the biggest life safer.

The roads are constantly under surveillance and better road surfaces are being investigated. A 70 mph speed limit is in operation on motorways and depending on the road and the area through which it runs there are speed limits of 30,40 and 50 mph in operation. In cases of accidents, fog or other hazardous conditions provision has been made for alterations in the speed limit.

Pedestrian bridges across very busy roads are being built. The radio and television are now used to give relevant information regarding roads and road users.

The police in conjunction with parents, education departments and organisations such as the boy scout movement, are teaching road safety. Child cyclists are encouraged to take proficiency tests.

Motor vehicle standards are improving and research is continuous. Recently because of the number of bad tyres on vehicles, the police have been carrying out spot checks and individuals can be fined if the tread of a tyre is below the stated requirement. Every vehicle of three years and over must have an annual test by a Certified garage and a statement issued indicating the vehicle is road worthy.

The Cost of Accidents

These are immeasurable in terms of pain, grief and suffering. Apart from this they represent a quantifiable loss to the community in economic terms which includes loss of output, cost of medical treatment, the time taken by police and courts, and the damage to property - this was estimated for a fatal accident at £13,000.

Total Cost

Medical Treatment, ambulance and funeral	-	£17 million
Police and administration	-	£28 million
Damage to vehicles and other property	-	£198 million
Lost output	-	£103 million
		£346 million

On average road accidents result in an economic loss of approaching £1 million per day, plus the human suffering involved which in money terms is unquantifiable

Home Accidents

During 1971 there were 6,245 accidental deaths in and around the home, 237 (or 3.7 per cent) fewer than in the previous year. Further analysis shows that the number of people who died in private homes fell by 117, and the number in residential institutions by 120.

SUMMARY

Cause of Death	Private Homes	Residential Institutions	Total Deaths
Poisoning	760	11	771
Falls	2824	1034	3858
Burns and Scalds	656	33	689
Suffocation and Choking	483	78	561
Others	334	32	366
TOTAL	5057	1188	6245

Every year more people die from falls than from all other accidents in the home, and as many as 62 per cent of the 6,245 fatalities in 1971 resulted from falls. Poisoning accounted for a further 12 per cent of deaths: burns and scalds for 11 per cent, and suffocation and choking for 9 per cent. The remaining deaths were due to miscellaneous causes.

CAUSE, AGE-GROUP AND SEX

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65&+	Male	Female	
Poisoning	24	15	205	262	265	339	432	771
Falls	55	16	94	262	3431	1061	2797	3858
Burns and Scalds	103	38	49	109	390	285	404	689
Suffocation and Choking.	301	18	77	82	83	333	228	561
Others	74	16	65	67	144	185	181	366
TOTAL	557	103	490	782	4313	2203	4042	6245
Death Rate*	14.2	1.3	2.6	6.6	67.4	9.3	16.1	12.8

*Deaths per 100,000 population

Elderly people are especially prone to domestic accidents and this is reflected in the statistics— over two thirds of the victims were aged 65 and over. Children under five years old accounted for a further nine per cent of the total.

An alternative anaylsis of the data indicates that 65 per cent of the victims in 1971 were female.

FALLS

Cause of Death	Age-group					Sex		Total
	0-4	5-14	15-44	45-64	65&+	Male	Female	Deaths
Falls on Stairs	10	5	45	118	497	276	399	675
Falls from ladders	-	-	4	18	22	37	7	44
Falls from buildings	12	4	22	14	46	55	43	98
Other falls from one level to another	23	5	8	17	274	95	232	327
Falls on same level	-	-	4	12	352	72	296	368
Other and unspecified falls.	10	2	11	83	2240	526	1820	2346
TOTAL	55	16	94	262	3431	1061	2797	3858

Accidental falls caused 3,858 deaths in the home during 1971. This is three more than in the previous year, but 34 fewer than in 1969 and 87 fewer than in 1968.

Women accounted for 76 per cent of the deaths among the over 65's, but less than half the deaths in the remaining age-groups.

POISONING

Cause of Death	Age-group					Sex		Total
	0-4	5-14	15-44	45-64	65&+	Male	Female	Deaths
Barbiturates	-	-	78	148	104	123	207	330
Analgesics and antipyretics	4	1	16	8	2	14	17	31
Other sedatives	-	-	15	12	8	11	24	35
Nervous System and pyschotherapeutic drugs	5	2	20	9	3	19	20	39
Other and unspecified drugs.	4	2	12	13	6	18	19	37
Alcohol	-	-	9	15	5	16	13	29
Other solids and liquids.	5	-	4	3	3	10	5	15
Total solids and liquids.	18	5	154	208	131	211	305	516
Piped gas	1	6	30	34	98	79	90	169
Motor vehicle exhaust gas.	-	-	9	7	1	17	-	17
Other carbon Monoxide gases.	4	3	12	10	32	29	32	61
Other gases and vapours.	1	1	-	3	3	3	5	8
TOTAL gases and vapours.	6	10	51	54	134	128	127	255
TOTAL	24	15	205	262	265	339	432	771

A total of 771 people died from accidental poisoning during 1971. This is 48 fewer than in 1970, 55 fewer than in 1969 and 107 fewer than in 1968.

A total of 169 people were accidentally poisoned by ordinary domestic gas in 1971, compared with 407 in 1968. The main reason for this improvement is the gradual introduction of natural gas which is non-toxic.

BURNS AND SCALDS

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65&+	Male	Female	
Ignition of clothing	4	7	5	18	108	38	104	142
Burns from controlled fire	3	1	1	9	65	31	48	79
Conflagration	79	28	30	49	111	144	153	297
Other and unspecified burns	7	-	11	28	73	55	64	119
TOTAL,Fire and flames	93	36	47	104	357	268	369	637
HOT substance, corrosive liquid and steam	10	2	2	5	33	17	35	52
TOTAL	103	38	49	109	390	285	404	689

There were 689 deaths from accidental burns and scalds during 1971, 111 fewer than in 1970, 76 fewer than in 1969 and 92 fewer than in 1968. At least 77 of the 637 deaths from fire and flames were caused by matches and cigarettes, etc.

SUFFOCATION AND CHOKING

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65&+	Male	Female	
Inhalation and ingestion of food	170	4	43	58	71	193	153	346
Inhalation & ingestion of other objects	12	1	2	6	7	15	13	28
Suffocation in bed or cradle	92	-	3	3	1	57	42	99
Other and unspecified suffocation	27	13	29	15	4	68	20	88
TOTAL	301	18	77	82	83	333	228	561

A total of 561 people died from accidental suffocation and choking in 1971. This compares with 635 deaths in 1970, 651 deaths in 1969 and 649 deaths in 1968.

Nearly a third of the 561 deaths were caused by young children under five years of age choking over their food.

OTHER CAUSES

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65&+	Male	Female	
Drowning and submersion*	33	2	14	12	24	46	39	85
Electric current+	7	5	31	15	12	47	23	70
Excessive cold	-	-	1	4	33	13	25	38
Hunger, thirst, exposure and neglect.	13	-	1	9	23	16	30	46
Struck by falling object	5	2	4	3	5	12	7	19
Striking against or struck by object	4	2	3	3	7	10	9	19
Cutting or piercing instruments	2	1	-	8	4	10	5	15
Other and unspecified	10	4	11	13	36	31	43	74
TOTAL	74	16	65	67	144	185	181	366

The remaining 366 accidental deaths which occurred in and around the home during 1971 were attributed to other miscellaneous causes.

*A total of 529 people were accidentally drowned in England and Wales during 1971. Although only 85 of these accidents occurred at home, the majority of the remaining deaths were associated with every-day leisure activities.

† Excludes burns by heat from electrical appliances.

'OPEN VERDICT' DEATHS

In addition to the 6,245 fatal accidents, 475 people died in or around the home, but it was impossible to determine whether death was accidental or purposely inflicted. Such cases are classified as 'open verdict' deaths.

As many as 358 of the 475 deaths were attributed to poisoning by various solids and liquids, and a further 28 deaths to gas poisoning. Twenty-five people died by drowning, and 21 people by hanging, strangulation or suffocation.

SECTION B

GENERAL PROVISIONS OF HEALTH AND SOCIAL SERVICES.

Laboratory Service: The Public Health Laboratory Service operating at the General Hospital, Northampton was available for the diagnosis and analysis of specimens relative to infectious disease, and also for the bacteriological examination of water samples, and was free of cost to the authority. A helpful and efficient service is provided, and we thank the laboratory staff for their constant co-operation.

Ambulance Service: Local ambulances under the control of the County Council are used for cases occurring in the district.

Nursing in the Home, Midwives and Health Visitors Service: These are provided directly by the County Council, who have their nurses living in various parishes in the district.

Child Welfare Centres and Clinics: Infant Welfare Clinics were held at Braunston, Welton and Woodford Halse. In addition the villages of Barby, Crick, Kilsby, Newnham, Norton, Staverton, Weedon, West Haddon and Yelvertoft were visited by the mobile caravan clinic, which was instituted to give clinic service to areas previously lacking this amenity. Transport facilities were provided by the County Council in various parts of the District for mothers and children to attend clinics at a nearby centre.

Hospitals: Those suffering from infectious disease were treated at Harborough Road Isolation Hospital, Northampton. Sufferers from tuberculosis who required institutional treatment were sent either to Creaton or Rushden House Sanatoria. The majority went to Creaton.

All other general and surgical cases were treated at Northampton General Hospital, Danetre Hospital, Horton Infirmary, Banbury, or Hospital of St. Cross, Rugby. The continued treatment of patients at Danetre Hospital has been beneficial to the District, for patients and friends alike.

WELFARE OF THE AGED.

National Assistance Act, 1948, and Section 47, National Assistance (Amendment) Act, 1951.

Under this section the Council is responsible for the removal to suitable premises of persons needing care and attention. No action was necessary under this Act, this year.

SERVICES FOR OLD PEOPLE.

The following provide services for old people:-

1. The National Health Service
   - (a) General Practitioner Service.
   - (b) Hospital and Specialist Service.

2. The County Council
   - (a) The Health Department
     1. District Nurses
     2. Health Visitors
     3. Chiropody Services
     4. Certain Home Equipment

(b) The Social Services Department

From the 1st April 1971 the Social Services Department was established in accordance with the requirements of the Local Authority Social Services Act, 1970. In Northamptonshire the department was formed by the amalgamation of the former Childrens' and Welfare Departments, together with several functions which were previously the responsibility of the Health Department, including certain child health functions, care of the handicapped, and Mental Health and Home Help sections.

The following services are now provided for the elderly by this Department:-

1. Home Help Service. This is of inestimable value in the prevention of breakdown in the aged, and many are able to remain in their own homes who would otherwise have to be removed to institutions.
2. Residential Accommodation.
3. Holidays for the elderly.
4. Special services for the blind and deaf, and home fittings where necessary.

3. Department of Health and Social Security.

Financial help where necessary.

4. The District Council

Homes for the aged, flats, and in some cases flatlets with Warden supervision.

A warden supervised scheme for the elderly has recently been completed at Greenhill Court, Long Buckby, comprising 20 single and 4 double flatlets. Further similar schemes are planned for Weedon and Woodford Halse. There are a total of 234 bungalows, many of which are occupied by the elderly. In addition 8 bungalows have recently been completed at Flore - though not yet occupied - a further 3 are being erected at Woodford Halse.

5. Voluntary Organisations.

Theseare many and services vary in different areas. They include holiday schemes in which old people are taken on seaside holidays in off-season times; the Darby and Joan Clubs; "Meals on Wheels" Service; the Home Visiting. The Women's Voluntary Service very often undertakes many of the above duties, while in other areas local voluntary committees run the various organisations. The Rural Communities' Council, together with the Old People's Welfare Committee, provide co-operation between the various services. Old People's Clubs are organised voluntarily in a number of villages in the District. The ladies and gentlemen who run these clubs provide a service to the community which is of immense value, and are to be thanked for their constant and untiring effort.

In the past, reports have been given on the activities of these clubs. As many of these are now established to an annual pattern the regular presentation of a report is no longer necessary, though from time to time reports will be presented.

The following villages have Old People's Clubs:-
Badby, Barby, Braunston, Byfield, Crick, Flore, Kilsby, Long Buckby, Newnham, Stowe-ix-Churches, Weedon, Welton, West Haddon, Woodford Halse and Yelvertoft.

SECTION C

SANITARY CIRCUMSTANCES OF THE DISTRICT

Water Supplies: All parishes of the District, with one exception, have mains water supplies under the control of the Mid-Northamptonshire Water Board. At Ashby St. Ledgers the supply is privately owned and controlled. Only a very few isolated farms and cottages do not have a mains supply, relying on pumps and wells, but each year there are more connections to the mains There are generally adequate supplies of pure wholesome water available, which is treated by chlorination and all supplies are regularly analysed by the Board. The main source of the water is Pitsford Reservoir situated 12 miles from Daventry where the water is constantly checked for purity.

The water is pumped from Pitsford to a local reservoir on Borough Hill overlooking Daventry. The water is moderately hard in character, and apart from a minute trace of iron, metals are absent; it has no plumbo solvent action.

Chemical Analysis:

Source of Water: Pitsford Reservoir.

Appearance	Clear and Bright
Taste/Odour	None
Colour (^{o}Hazen)	Less than 5
Turbidity (Fullers Earth)	Nil
pH	8.1
Electrical Conductivity (micromhos)	496
Suspended Solids	Nil
Total Dissolved Solids	365
Total Hardness ($CaCO_3$)	210
Temporary Hardness ($CaCO_3$)	140
Calcium Hardness ($CaCO_3$)	145
Chloride (Cl)	36
Sulphate (SO_4)	110
Permanganate Value (4 hrs)	1.2
Ammoniacal Nitrogen (N)	0.01
Albuminoid Nitrogen (N)	0.12
Nitrate (N)	3.9
Nitrite (N)	Nil
Iron (Fe)	Less than 0.04
Manganese (Mn)	Nil
Residual Chlorine (Cl_2)	0.6 at source
Heavy Metals (Cu, Zn, Pb)	Nil
Fluoride (F)	0.3
Silica (SiO_2)	3

(Results in mg/l unless otherwise stated)

STATISTICS SHOWING HOUSES WITH PIPED OR NON-PIPED WATER SUPPLIES.

	Houses with Laid-on	Piped Supply Stand Tap	Houses with Non-Piped Supply.
Ashby St. Ledgers	49	3	3
Badby	204	6	3
Barby	301	2	3
Braunston	534	3	3
Brockhall	6	-	2
Byfield	367	2	4
Canons Ashby	6	-	4
Catesby	25	-	4
Charwelton	46	-	3
Clay Coton	14	-	1
Crick	412	3	4
Dodford	48	4	4
Elkington	13	-	6
Everdon	144	-	3
Farthingstone	54	3	2
Fawsley	9	-	4
Flore	429	4	4
Hellidon	58	-	2
Kilsby	331	-	4
Lilbourne	109	-	3
Long Buckby	1005	4	4
Newnham	168	-	4
Norton	112	6	4
Preston Capes	65	-	3
Stanford	10	-	2
Staverton	141	-	4
Stowe-ix-Churches	74	4	3
Watford	80	2	4
Weedon	587	5	4
Welton	187	3	3
West Haddon	333	-	4
Whilton	55	9	4
Winwick	33	-	1
Woodford Halse	635	2	5
Yelvertoft	289	-	4
	6940	65	119

SEWAGE DISPOSAL, SEWERAGE AND DRAINAGE

The new scheme at Whilton was completed during the year. Alterations at the Braunston Works, and the Staverton and Hellidon scheme progressed, and it is anticipated that both these projects will become operational early in 1973. Plans for the Long Buckby Regional Scheme (incorporating Ashby St. Ledgers and West Haddon) were submitted to the Department of the Environment for formal approval towards the end of the year.

The Public Health Committee are continually reviewing existing schemes and wish to initiate new schemes in those parishes without proper sewage disposal, but costs continue to rise and government grants to such new schemes has to be carefully apportioned, these together give rise to problems which the Committee have to consider when assessing future schemes or extensions of existing schemes. The over loading of the works in some parishes is causing much concern and has resulted in the temporary stopping of building development in those parishes. The following table shows the parishes of the District with modern sewage disposal schemes.

Ashby St. Ledgers	Lilbourne
Badby	Long Buckby
Barby	Newnham
Braunston	Norton
Byfield	Staverton
Charwelton	Watford
Crick	Weedon
Everdon	Welton
Farthingstone	West Haddon
Flore	Winwick
Kilsby	Woodford Halse
	Yelvertoft

This means that 23 parishes of the District, out of a total of 35 have proper sewers and sewage disposal works. Of the remaining 12 parishes 7 altogether have a total of just over 100 houses, the other 5 each has over 60 houses in the parish. These parishes are constantly under review by the Committee.

The general drainage in all the sewered parishes was satisfactory but in those with no sewers sewage often reaches open dykes, thereby causing much expense in cleansing and maintenance to obviate any possible nuisances. There are a large number of septic tanks to individual houses which require cleansing by outside contractors. This situation causes difficulty to householders, as they are not always readily available when urgently required.

DETAILS OF OTHER DUTIES OF THE PUBLIC HEALTH DEPARTMENT.

DISINTECTION AND DISINFESTATION: No cases of disinfection were carried out, no bed bugs were reported. 70 waspsnests were destroyed, 38 premises were treated for fly infestation and 24 premises for ants infestation.

THE CARAVAN SITES AND CONTROL OF DEVELOPMENT ACT, 1960: All sites are licenced for single caravans only. None of the sites gave cause for complaint.

PREVENTION OF DAMAGE BY PESTS ACT, 1949: The scheme continues to operate with success. The operator spent the greater part of his time on pests control, which includes rats and mice, wasps, flies and ants. Minor infestation at refuse tips and sewage works were speedily controlled. All refuse tips and sewage works are constantly under inspection and permanent baiting points have been maintained around the perimeters of these premises. There has been much work in connection with household complaints and these have been dealt with by the operator at no cost the the householder. A marked increase in the numbers of complaints concerning mice has occurred; the usual practice has been to visit the premises concerned, put down an initial bait and then leave a replenishment of poisoned bait with the householder. This procedure appears to have been successful. As in previous years, the Ministry of Agriculture, Fisheries and Food (Pests Division) have launched campaigns along with other local authorities, farmers, water-boards, river authorities, electricity undertakings and the forestry commission for the destruction of rats and mice. Some success has been achieved as a result of this action. The Councils' rodent operator visited farms to arouse interest and co-operation amongst the farmers, and many did give earnest attention to their premises. The need for continual action against the rat and mouse cannot be too strongly emphasised. Permanent baiting points should be provided at all farm premises and lands, at food premises and stores, or any situation likely to create a breeding ground. Baiting points should be continually checked and replenished when necessary and must be protected from domestic animals.

The following table shows the extent of the operative's work:-

Inspection of private dwellings	279
Inspection of council dwellings	267
Inspections and visits to farm premises	67
Treatments to private dwellings	252
Treatments to council dwellings	97
Total visits during treatment	1077
Number of sewer manholes baited	305
Number of follow up visits necessary	730
Number of treatments to sewage works	91
Number of follow-up visits necessary	310
Number of treatments to refuse tips	28
Number of follow-up visits necessary	167
Wasps nests destroyed	70
House fly infestations treated	38
Ants infestations treated	24
Mice packs issued	228

Total mileage covered by van 12,221 miles

Poison used:

Warfarin(1) Master-Mix	64 lbs.
Sewer Warfarin	356 lbs.

Bait used:

Pinhead Oatmeal	760 lbs.

REFUSE COLLECTION: The regular weekly collection of house-hold refuse continued throughout the district and there was little complaint from the public concerning this service. Unfortunately, the collection of waste paper had to be discontinued for economic reasons, as the prices received for baled waste did not warrant the labour involved, and paper now goes with other refuse for deposit on the tips. The expansion of the area and the introduction of new industries with higher rates of pay, resulted in some loss of staff. However, the labour force was successfully maintained. The Council had approved an incentive bonus scheme which was satisfactory and a further incentive to keep the staff. The building of new houses has resulted in an increase in the amount of refuse collected and the content of refuse has changed over the past few years, now largely consisting of vegetable, paper, tins and bottles, making tip control more difficult to maintain at a reasonable level. The Council has undertaken the removal of abandoned vehicles from the verges, of refuse from hedgerows and dykes, and house-holders can also have large refuse and unwanted household articles removed, at a nominal cost, by the Council. The tip at Dodford takes all the refuse from the northern part of the district and part of the southern area, and is now approaching completion. The Council however, have an alternative tip on the A5 which has required considerable preparation prior to receipt of the refuse when the old tip is full.

The tip at Woodford Halse receives refuse from Preston Capes, Canons Ashby, Byfield, Charwelton, Hellidon and Woodford, and is now becoming full, but the Council have made good provision for an alternative site by purchasing the disused railway cuttings at Woodford Halse, which will take a large amount of refuse for a long period. Fires have continued to be a source of much expense and concern, and require the transport of earth moving equipment to the sites when they occur.

PETROLEUM (REGULATIONS) ACTS 1928 & 1936

Number of licences renewed was	66
Number of licences granted was	2

PUBLIC HEALTH ACT, 1936 (Part X) CANAL BOATS: There is no canal work of carrying cargo in this area. The wharves at Braunston were again busy during the summer months with trade for canal cruising holidays increasing. There is a small repair dock at Braunston, which creates some local employment.

FACTORIES AND WORKSHOPS ACTS, 1937 TO 1961

Annual Report of the Medical Officer of Health in respect of the year 1972 for the Rural District of Daventry in the County of Northants. Prescribed particulars on the Administration of the Act.

PART 1 OF THE ACT.

1.-INSPECTIONS for the purpose of provisions as to health (including inspections made by the Public Health Inspector).

	Premises	Number on Register	Inspections	Number of Written Notices	Number of Occupiers Prosecuted
(i)	Factories in which sects 1,2,3,4 and 6 are to be enforced by Local Authority.	-	-	-	-
(ii)	Factories not included in (i) in which section 7 is enforced by Local Authority	54	54	-	-
(iii)	Other premises in which section 7 is enforced by the Local Authority (excluding outworkers premises.	-	-	-	-

2.-CASES in which defects were found (If defects are discovered at the premises on two, three or more separate occasions they are reckoned as two three or more cases).

Particulars	Number of cases in which defects were found: Found	Remedied	Referred to H.M. Inspector	Referred by H.M. Inspector	Number of Cases in which prosecutions were instituted
Want of Cleanliness (S1)	2	2	-	-	-
Overcrowding (S2)	-	-	-	-	-
Unreasonable Temperature (S3)	-	-	-	-	-
Inadequate Ventilation (S4)	-	-	-	-	-
Ineffective drainage of floors. (S6)	-	-	-	-	-
Sanitary Conveniences (a) insufficient	-	-	-	-	-
(b) defective	1	1	-	-	-
(c) not separate for sexes.	-	-	-	-	-
Other offences relating to Outworkers.	-	-	-	-	-
Totals	3	3	-	-	-

No lists of Outworkers were received.

OFFICES SHOPS AND RAILWAY PREMISES ACT, 1963

This Act was introduced to establish a standard of health, welfare and safety in relation to the working conditions of persons employed in premises coming within the scope of the Act.

These premises include offices, shops, hairdressers, hotels, public houses, restaurants, transport cafes, canteens, wholesale warehouses and fuel storage depots.

The Act lays a duty on the Local Authority to appoint inspectors to enforce the provisions of the Act and the Public Health Inspectors have been so appointed by this Council.

The provisions of the Act, and the more detailed requirements of the Regulations made thereunder which are enforceable by the Local Authority are briefly as follows:

1. Maintenance of general cleanliness
2. Provision of adequate working space
3. Maintenance of a reasonable temperature and provision of a thermometer.
4. Provision of adequate and suitable lighting and ventilation.
5. Provision of suitable and sufficient sanitary conveniences and washing facilities.
6. Provision of adequate and wholesome supply of drinking water.
7. Provision of suitable and sufficient seating facilities.
8. Provision of suitable and sufficient accommodation, including drying facilities for working and outdoor clothing.
9. Provision of suitable and sufficient eating facilities for the use of employed persons who are required to eat meals on the premises.
10. Construction and maintenance of secure fences on machines to guard against injury.
11. Prohibition of persons under 18 years of age from cleaning machinery if it exposes them to injury from moving parts.
12. Prohibition of any person from working at any machine prescribed by an Order as being dangerous, unless he has received adequate safety training or is under adequate supervision.
13. Prohibition of any person being required to lift or move loads so heavy as to cause injury to him.
14. Provision of a first-aid box to contain specified numbers of dressings, etc., depending upon the number of employees and class of premises.
15. Notification of accidents to Local Authority
16. Construction and maintenance of all floors, passages, stairs etc., to reduce risk of accidents.
17. Display of an Abstract of the Act and Regulations for information of employees.

Routine inspections were made of registered premises and the contraventions which were found to exist included dangerous floors and stairs, defective meat slicing equipment, inadequate means of space heating, ineffective lighting and inadequate toilet and washing facilities.

(B) ANALYSIS OF CONTRAVENTIONS

Section	Number of Contraventions found		Section	Number of Contraventions found	
4	Cleanliness	2	13	Sitting facilities	-
5	Overcrowding	-	14	Seats (Sedentary Workers)	-
6	Temperature	2			
7	Ventilation	-	15	Eating facilities	-
8	Lighting	-	16	Floors,passage and stairs.	3
9	Sanitary Conveni-ences.	-	17	Fencing exposed parts machinery	2
10	Washing facilities	-	18	Protection of young persons from dangerous machinery.	-
11	Supply of drinking water.	-	19	Training of young persons working at dangerous machinery	-
12	Clothing accommod-ation.	-	23	Prohibition of heavy work.	-
			24	First Aid	6
				Hoists and lifts	-
				Other matters	-
				TOTAL	15

All new businesses were visited as soon as possible in order to secure registration and to advise the owners of their obligations under the Act. In most cases the employers were glad to have the complexities of the Act explained to them and good co-operation has been achieved in the carrying out of the various works.

Details of any accident that occurs on registered premises, involving death, or disablement for more than 3 days, require to be sent to the Local Authority. 3 notifications were received during the year of non-fatal accidents resulting in fractures, lacerations and bruising. Falls account for the majority of these accidents and this cause is confirmed by national statistics of accidents. Employees should ensure the correct use of proper equipment for reaching goods at high level and liquid spillage on floors which produces a slippery condition should be reduced to a minimum.

(A) REGISTRATION AND GENERAL INSPECTIONS

Class of Premises	Number of premises registered during the year.	Number of registered premises at end of year.	Number registered premises receiving a general inspection during the year
Offices	1	7	6
Retail Shops	-	32	32
Wholesale shops, Warehouses.	1	2	1
Catering establishments open to the public, canteens.	1	16	16
Fuel storage depots	-	1	-
Totals	3	58	55

Total number of visits of all kinds by inspectors to registered premises under the Act. 93

TABLE 3. EXEMPTIONS NIL

TABLE 4. PROSECUTIONS NIL

TABLE 5. INSPECTORS

No. of Inspectors appointed under Sections 52 (1) or (5) of the Act. (Existing Staff) 2

No. of other staff employed for most of their time on work in connection with the Act. NIL

The Deposit of Poisonous Waste Act, 1972

This Act placed a general prohibition on the depositing of poisonous and other dangerous waste, made it a civil liability to do so, and laid the duty of those wishing to deposit to notify the responsible authorities prior to removal or deposition. Operators of commercial tips had also responsibility for notification and duties of local authorities were outlined in relation to enforcement of the Act.

Future Problems in Environmental Health

While the foregoing is a report on the year 1972, at this historic time it is relevant to consider some of the problems which will face the reorganised department of environmental health in 1974.

The disposal of refuse, and the overall control of sewage works will become the responsibility of County Councils and Water Authorities respectively. District Councils will retain their responsibility for sewering, and collection of refuse. The need for cooperation between authorities will be paramount. Likewise while the personal health services will be part of the National Health

Service, environmental health together with the control of infectious diseases remains a District Council duty.

Successful environmental control can, however never be achieved without consideration of the personal co-operation of the individuals living in the community. This is evident in its most pressing form in the need for population control. Unless achieved within the remaining years of the century the task of those endeavouring to maintain environmental health will be overwhelming. Already the environment is threatened by congestion on roads and countryside, noise, pollution of air, land, waterways and sea, housing shortages and the need for more services in many fields. The effect of this on the mental health of the people can be inferred by the increase in crime, delinquency, drug taking, alcoholism and child cruelty. The reorganised health service will have the responsibility for providing contraceptive services and plans to expand are already afoot. However in the acceptance by the population of these measures an enlightened health education service will have a vital part to play. Other aspects of health education will be shared by both authorities, Local Government accepting the need to provide instruction, particularly in safety at home, at work and on the road, and in food hygiene.

It is vital that the secure basis already achieved in the sanitary field is maintained, and the need for the prevention of further pollution, often from products innocently introduced for man's convenience, will be a major function. In rural areas, mass production methods in farming are creating further problems, particularly of smell and pollution and will ultimately require a system of national standards of control.

SECTION D.

HOUSING

Further development is dependent on the availability of land and the greatly increased building cost is another deterrent to the provision of housing. The Grouped Dwelling at Greenhill Court, Long Buckby was near to completion at the end of the year and it was expected that the new tenants would be moving in early in the New Year, a similar type Grouped Dwelling at Riverside Court, Weedon was also progressing, and a further Grouped Dwelling is planned for Woodford Halse. 8 bungalows and 3 bungalows were in course of construction at Flore and Woodford Halse respectively, those at Flore would be allocated early in the New Year.

The figure of existing council houses becoming vacant and available for re-letting was 62, compared with 63 the previous year. Some were allocated to persons living in unfit houses, the remainder to the waiting list.

There was a waiting list of 485 applicants, at the end of the year, for council accommodation. Of this number 234 lived in the particular parish, 64 not in the parish but within the area of the Rural District, and the remaining 187 lived outside the area of the District.

Steady progress was maintained in dealing with unfit properties, houses being dealt with as they became vacant and replacement houses were therefore not required, and in some instances persons from unfit houses were re-housed in vacant council houses. In addition a number of properties were made habitable by the use of Improvement Grants. A greater number of unfit houses could be dealt with if new houses were built. A progress report is given later in this section.

Council Houses re-let by parish representatives	62
Council tenants given permission to take lodgers	2
Internal exchanges of council houses permitted	11
External exchanges of council houses permitted	3
Council house tenancies transferred (due to death of tenant, or, domestic trouble)	45
Council garages re-let	6

There is no Common Lodging House in the District.

It is pleasing to report that 167 privately owned houses and bungalows were completed and occupied during the year, this is a decrease compared with the previous, but still a good rate of progress. The dwellings completed were mainly inthe parishes of Barby, Byfield, Crick, Kilsby, Long Buckby, Weedon, West Haddon and Yelvertoft.

HOUSING (FINANCIAL PROVISIONS) ACT 1958
HOUSE PURCHASE AND HOUSING ACT 1959.
HOUSING ACT, 1961 HOUSING ACT, 1964.
HOUSING ACT, 1969

During the year there were twice as many applications for Improvement Grants as compared with the previous year, with a slight decrease in the number of applications for Standard Grant. The Housing Act had enhanced the amount of grant aid for both types of grant and the sale restriction on property improved by grant aid was removed.

The summaries given below show the amount of work which has been necessary for the inspection of the proposed works and after completion of approved works, to qualify for payment of the Council's share of the grant.

DISCRETIONARY GRANT:

The number of applications received and approved showed an increase, there being 36 as compared with 18 the previous year. The cost of the improvement grant aid was £31,596, and of this the Council contributes 25% and the Department of the Environment the remainder. The total cost of the works approved was £101,306.

Since the Act came into force 409 applications have been received for grant aid. Of these 19 were withdrawn by the applicants, 56 were not approved due to failure to comply with the requirements of the Acts and 334 have been approved, costing some £126,697 in grant aid. By the end of the year works in respect of 284 applications had been completed and grant paid.

STANDARD GRANT:

36 applications were received during the year, compared with 37 the previous year. All were approved by the Council. Of this number 29 were from owner-occupiers and 7 from owners of tenanted houses. These approved grants showed a total amount to be paid of £6,433. By the end of the year 567 applications for this type of grant had been approved by the Council, and since the Act came into force, involving a sum of £90,204 in grant aid payment. Further, at the end of the year, works in respect of 475 applications had been completed and grant paid.

(B) HOUSING ACT 1969 - PART 111

Rent of dwellings in good repair and provided with standard amenities.

1. Sn.45. Qualification certificates

(a)	applications:	received	7
(b)		Granted	2
(c)		refused	5
(d)	appeals (i)	allowed	Nil
	(ii)	disallowed	Nil

2. Sn46. Certificates of provisional approval

(a)	applications	received	6
(b)		granted	6
(c)		refused	Nil

HOUSING ACTS 1936 - 1957

1. Inspection of dwelling houses during the year:

(a)	Total number of dwelling houses inspected for housing defects under the Housing and Public Health Acts	727
(b)	Inspections made for the purpose	969
(c)	Number of dwelling houses (included above) which were inspected and recorded.	321
(d)	Number of dwelling houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation.	212

2. Remedy of defects during the year without service of formal notice:

Number of houses made fit in consequence of informal action by Public Health Inspector.	45

3. Action by Local Authority under the Housing and Public Health Acts by serving of informal notices:

(a)	Under the Housing Acts.	
	Number of houses requiring defects to be remedied	26
	Number of houses defects remedied by owners	26
(b)	Under the Public Health Act.	
	Number of houses requiring defects to be remedied	25
	Defects remedied by owners	25

4. Proceedings under sections 16 and 17 Housing Act, 1957:

(1)	Number of Demolition Orders made	3
(2)	House demolished, a sequence to Demolition Orders	4
(3)	Number of Undertakings accepted	-
(4)	Houses demolished, after Undertakings accepted	-
(5)	Undertakings cancelled, houses made fit	-
(6)	Number of Closing Orders made, separate dwellings	12
(7)	Closing Orders determined	5
(8)	Houses demolished, after Closing Orders	10
(9)	Houses upgraded to category '1' or '2', repairs and improvements having been carried out.	44
(10)	Dwellings put to other use	2
(11)	Houses voluntarily demolished by owners, after informal action	8

The number of houses dealt with during the year, for the first time are shown at (1);(6);(9);(10) and (11).

OVERCROWDING

As a result of the Council's own re-housing, it was known that 9 cases of overcrowding, involving some 35 persons, were abated.

HOUSING ACTS 1936-1957

No Clearance Areas were made by the Council during the year. Unfit houses were dealt with under sections 16 and 17 of the Housing Act 1957 as either Individual Demolition Orders or as Closing Orders, while 44 properties were dealt with by the owners after informal action and upgraded in category. The year's work regarding this aspect of housing is given above.

Up to the end of 1971. a total of 930 houses had been dealt with, add to that the 69 dealt with in 1972, a total of 999 houses is reached.

However, during July and August, a re-check was made in all parishes of the District with low category houses still remaining, and at the same time, inspection was made of additional houses which have now deteriorated, a total of 640 houses were inspected, 30 were up-graded 398 were considered capable of reaching the 12 point standard if the necessary repairs and improvements were carried out, and 212 houses were considered incapable of reaching the 12 point standard and were considered as unfit and should be dealt with.

There has been some interest in the improvement and modernisation of the old type houses, and the Council are only too pleased to approve applications for Improvements Grants, there was an increase in the numbers applying for grants. Both types of grant have been extensively advertised in the daily national and local press and on radio and television.

It has been possible to move some tenants from unfit houses to vacant council houses but lack of building land prevents any real progress in some parishes where the housing problems are most acute. The rate appears slow, but the objective is being achieved. A large number of unfit houses are occupied by elderly persons, who are also the owners, and many have just a single occupant. It has been the policy to deal with this type of house as it became vacant; The following table gives the number of unfit houses dealt with and more particularly shown as (a); (c); (f); (i); (l) and (m) up to 31st December.

(a)	Houses dealt with in Clearance Areas	84
(b)	Houses in Clearance Areas and now demolished	84
(c)	Houses in Demolition Orders	187
(d)	Houses in Demolition Orders, now made fit	4
(e)	Houses in Demolition Orders and demolished	140
(f)	Houses in respect of which Closing Orders were made (separate dwellings)	247
(g)	Houses as Closing Orders, now made fit	98
(h)	Houses as Closing Orders, now demolished	75
(i)	Houses in respect of which, Undertakings were accepted.	140
(j)	Houses in respect of which Undertakings were cancelled having been made fit.	61
(k)	Houses, where Undertakings were accepted, but now demolished.	52
(l)	Houses voluntarily demolished, after informal action.	59
(m)	Houses upgraded, repairs and improvements having been carried out by owners, after informal action.	280

SECTION E

INSPECTION AND SUPERVISION OF FOOD

The production and distribution of food has undergone major changes in the last quarter of the century. Technical advances, which have resulted in the manufacture of an increasing variety of food, with an improved keeping quality, quick transport, pure water, carefully controlled milk supply, and food hygiene legislation have all contributed to the raising of standards. However, many of the innovations have generated further problems of control and the increasing mobility of a rising population have added to, rather than lessened, the need for food hygiene supervision.

Many more premises are now vending food, some for immediate consumption. The almost universal use of refrigerator cabinets, while greatly improving hygiene, nevertheless requires careful stock rotation. There is an increase in the purchase of already cooked food for home consumption. The majority of the working population, including schoolchildren, take their midday meals at a canteen or cafe. Travel at home and abroad is general , the latter sometimes resulting in the importation of intestinal infections, not endemic in the local population, which in food handlers can cause grave concern. The rapid changes in personnel in the food industry need supervision and education from employers and inspectors.

MILK SUPPLY: The milk and Dairies (General) Regulations 1959 were in force and brought earlier regulations into line with modern methods of milk production.

The enforcement of the Regulations is the responsibility of the Ministry of Agriculture, Fisheries and Food, and as regards distribution and infected milk, the responsibility of the Local Authority.

The Milk (Special Designations) Regulations 1963 were in force and standardised the form of labelling milk in bottles and cartons. The labels on bottles or cartons are now either 'Untreated Milk'; 'Sterilised Milk';'Pasteurised Milk' or 'Ultra-Heat Treated Milk', although the term 'Milk from Tuberculin Tested Cows' may be used. The majority of dealers gave up the sale of 'Un-treated Milk' and now only sell 'Sterilised';'Pasteurised' or 'Ultra-Heat Treated Milk'; it is only the producer-retailer who still sell 'Un-treated Milk'. There is no firm in the district producing 'Pasteurised'; 'Sterilised' or 'Ultra-Heat Treated Milk'. There are 19 licenced dealers in the district, to which can be added the 4 large multiple firms, selling milk in all parts of the area. Supplies were generally satisfactory.

Regular sampling of milk (untreated) is carried out by the Weights and Measures Department of the County Council, who have kindly agreed to cooperate with public health departments in the county. Results of any tests which are not satisfactory are immediately reported and suitable action taken. This service has been of great assistance, and our thanks for this helpful method are accorded to the Weights and Measures Department. It is particularly useful in relation to brucella infection.

Existing procedure concerning brucella infection is unsatisfactory, as there is at present, no legal enforcement for the eradication of infected animals from the herd. The ministry have an incentive scheme for proven brucella free herds, and offer an increased gallonage payment from such herds, but it is a voluntary scheme.

The prevalence of brucella in the country cannot be estimated. The only satisfactory way to deal with this problem is the introduction of a scheme, similar to that applied for Tuberculin free herds, so that infected animals must be slaughtered and not permitted to be sold in the market and so set up the disease elsewhere.

There are no poultry processing premises within the district.

FOOD HYGIENE (GENERAL) REGULATIONS 1960/62

BAKEHOUSES: Three were operating in the District. Each has a small output, but serves a useful purpose to some of the surrounding villages. Bread is primarily distributed by multiple firms, either by direct delivery, or by sale to the shops for resale to the public. The bakehouses were regularly inspected and found to be satisfactory.

FOOD SHOPS AND CATERING ESTABLISHMENTS: as a direct result of an increase of staff in the Public Health Department, the number of detailed inspections in terms of the Food Hygiene (General) Regulations 1960/62 and the time that has been able to be devoted to each premise has increased considerably from previous years.

There would appear to be a general awareness by the public and shopkeepers that hygienic standards must be raised and a gradual improvement has been noted throughout the District. It must be said however in this context that the improvement in standards would be much accelerated if the public were to be more critical of the dirty condition of premises, the staleness of food and particularly the bad personal habits of the shop assistant in relation to the handling of food. By refusing to patronise the poorly conducted business the public would force the improvement of standards or alternatively the business would cease due to lack of custom. The Public Health Inspector would welcome the support and cooperation of the public in this matter and any complaints would be investigated and the necessary action taken.

Special problems arise at the Watford Gap Service Area on the M1 motorway mainly due to the 24 hour catering service that is provided. The shortage or change-over of staff or the arrival on-site of a large number of customers from a coach convoy create temporary difficulties but taking into account the scale of catering and throughput the number of complaints received are extremely few. Each complaint is however investigated and the necessary steps taken to prevent a recurrence. Frequent inspections are made and good cooperation is achieved with the management. During the year the health department have co-operated with the management in providing regular food hygiene education both to supervisory staff and in introductory courses to new recruits.

The increasing number of public houses in which meals are served poses a new and time consuming problem. Storage and preparation facilities in many cases only comprise a kitchen also used for domestic purposes and conditions fall short of the requirements of the Food Hygiene Regulations. Discussions will take place with the brewery managements and tenants in the ensuing year in order to effect the necessary improvements in equipment and premises.

Types of Premises covered by the Food Hygiene (General) Regulations 1960/62

Bakehouses with shops	3
Butchers Shops	16
Grocers Shops	52
Cafes	6
Canteens	10
Clubs	5
Public Houses	37
Public Houses with extensive catering	9
Motorway Service Area	1
Hotels	3
Motels	1

FOOD HYGIENE (MARKETS, STALLS AND DELIVERY VEHICLES) REGULATIONS 1966

In this District these Regulations mainly apply to mobile shops and food delivery vehicles.

Good progress is being made with the equipping of these vehicles to comply with the Regulations and many inspections have been made to ensure that hygienic methods of food handling are being maintained.

MEAT

There are two private licenced slaughter houses premises operated by butchers in connection with their own shops for local trade. There is no public slaughter house in the District. The two slaughter houses were maintained in a satisfactory condition and were frequently inspected, with an annual inspection by the Veterinary Inspectors of the Ministry of Agriculture, Fisheries and Food. Effective fly control was maintained in the cooling halls, etc., by means of electrically operated automatic aerosol dispensers which discharge at pre-determined intervals a measured quantity of insecticide suitable for use in food premises. Close attention was given to the methods of slaughter to ensure that humane practices were correctly observed. The stunning instruments in general use were the captive bolt for large animals and electric tongs for pigs, sheep and lambs. Regular inspections were also made of animal lairages, to ensure cleanliness, satisfactory water supply and when necessary adequate food.

All animals slaughtered for human consumption were inspected in accordance with the Meat Regulations, 1963, and if fit for food were stamped before release for sale. The table following shows the numbers and types of animals slaughtered and inspected and the amounts of meat and offal seized as unfit for food. Since the numbers killed and inspected showed a reduction on the figures for the previous year, there was a reduction in the amounts of offals and meats seized, the percentages of such seizures is also much lower than for the previous year. There were generally two weekly visits to each of the two private slaughter houses. It will be noted there was no instance of cysticercus bovis whilst there was 1 head of a pig seized, due to tuberculosis.

	Cattle Exclud, Cows.	Calves	Sheep and Lambs	Pigs
Number killed	220	3	920	447
Number inspected	220	3	920	447
All diseases, except Tuberculosis and C Bovis:				
Whole carcases condemned	-	-	-	-
Carcases of which some part or organ was condemned.	31	-	5	46
Percentage of the number inspected affected with disease other than T.B. or C.Bovis	14.0	-	.53	10.2
Tuberculosis only				
Whole carcases condemned	-	-	-	-
Carcases of which some part or organ was condemned	-	-	-	1
Percentage of the number inspected affected with T.B.	-	-	-	.22
Cysticercus only				
Carcases of which some part was condemned.	-	-	-	-
Carcases submitted to treatment by refrigeration.	-	-	-	-
Generalised and totally condemned	-	-	-	-
Weight of meat condemned (lbs)	15	-	-	27
Weight of offal condemned (lbs)	384	-	8	55

SECTION F

PREVALENCE OF AND CONTROL OVER INFECTIOUS AND OTHER DISEASES
HEALTH SERVICES AND PUBLIC HEALTH ACT, 1968
PUBLIC HEALTH (INFECTIOUS DISEASES) REGULATIONS
NOTIFICATION OF FOOD POISONING AND INFECTIOUS DISEASES

All provisions governing the notification of infectious disease and food poisoning are in Sections 47 to 49 of the Health Services and Public Health Act 1968 and the Public Health (Infectious Diseases) Regulations 1968.

The infectious diseases to be notified to the medical officer of health are:-

Acute encephalitis	Ophthalmia neonatorum
Acute Meningitis	Paratyphoid Fever
Acute Poliomyelitis	Plague
Anthrax	Relapsing Fever
Cholera	Scarlet Fever
Diphtheria	Smallpox
Dysentery (amoebic or bacillary)	Tetanus
	Tuberculosis
Infective Jaundice	Typhoid Fever
Leprosy	Typhus
Leptospirosis	Whooping Cough
Malaria	Yellow Fever
Measles	

Since 1968 notification of the diseases listed below is no longer required:

Acute influenzal pneumonia	Erysipelas
Acute primary pneumonia	Membranous croup
Acute rheumatism	Puerperal pyrexia

Responsibility for notifying a case or suspected case of food poisoning or infectious disease rests exclusively on the medical practitioner attending the patient unless he believes that another practitioner has already notified the case.

44 cases of Infectious Diseases were notified, showing a decrease compared with last year's figure of 114.

The majority were for measles

WHOOPING COUGH: (Pertussis) No cases were notified. The County Council are participating in a survey on the efficacy of pertussis vaccination with the Public Health Laboratory Service. Details of notifications together with (where possible) the vaccinal state of the child are provided. The surveillance will include an analysis of the attack rate in vaccinated and unvaccinated children in areas with computer facilities.

SCARLET FEVER: 1 case was notified, compared with 3 the previous year. The illness was very mild and no serious complications resulted. Its principal interest is that it gives a rough indication of the amount of streptococcal infection in the community.

MEASLES: The incidence of notification decreased, there being 38 cases, compared with 84 the previous year. While measles no longer is a major cause of morbidity in Britain, it is an unpleasant illness and few reach adult life without having contracted it.

In addition in the five years preceding 1968 there were 467 deaths. An infection of such universality may result in complications, including neurological sequelae and respiratory, eye and aural infections, and during an epidemic year as many as 8,000 hospital admissions may occur. The regular biennial cycle of epidemics of measles failed to occur in the 1968-69 winter and again in the winter of 1969-70 there was no national epidemic, due probably to the programme of immunisation which began in 1968. The suspension in March 1969 of a certain batch of vaccine led to a shortage and the rate of immunisation has been less than sufficient to prevent the number of susceptible children increasing with the new births each year. It was evident by the middle of 1970 that the incidence of measles would be high as notifications markedly increased and continued throughout the year. By mid-1970 sufficient supplies of vaccine were available and vaccination was resumed, however during late 1970 and throughout 1971 there was a significant rise of measles notifications nationally and a campaign, initiated by the Chief Medical Officer of the Department of Health, to promote further measles vaccination was successful and there was a considerable increase in the numbers of children vaccinated. During 1972 the figures continued to rise and in the county 5,752 children were vaccinated between the ages of 1 and 7 years. 72% of children born between 1st January 1968 and December 1971 were vaccinated.

It is hoped that a sufficient number of susceptibles will now be vaccinated and that 1971 will be the last year when a high incidence of measles is recorded.

RUBELLA: Rubella vaccination became available in November 1970 and this was offered to all girls in their 14th year of life, i.e. aged 13. Following the increased availability of the vaccines this age limit has now been lowered to include 11 and 12 year old girls.

Vaccination is also offered to female teachers of child bearing age because of the likelihood of their coming into contact with the infection in school. In the county 279 took up the offer, but only 31 had negative haemagglutination inhibition titres, who were vaccinated. Female members of the health department staff were offered similar facilities and 18 of 47 needed protection.

POLIOMYELITIS: No cases occurred. This gratifying state continues and now, with large numbers immunised, it is to be hoped that this infection will be eliminated. The importance of maintaining a very high percentage of immunisation in the population cannot be over emphasised. It has been found that with immunisation of a high percentage of the population there is a decline of circulation virus in the community and though themselves not immunised this helped to protect other members of the community from infection.

DYSENTERY: No cases were notified, as compared with 3 last year.

FOOD POISONING: The condition is usually caused by one of the Salmonella organisms, the commonest being the typhimurium strain or paratyphoid A or B. The Staphylococcus gaining an entry to food from an infected spot or boil on the hands, arm or face of a food handler may also cause a severe form of food poisoning. Occasionally food maybe chemically contaminated. Typhoid fever is a rare condition, but like the other salmonellae may gain entry into food by faulty hygiene of food handlers. The sources of infection can be numerous, uncooked contaminated (often imported) meat or poultry being today some of the commonest. Travel abroad resulting in the importation of infections is another source and can cause problems of hygiene in food handlers.

Three cases were notified.

The first case occurred in January in an elderly man who subsequently died, and although the infection was not the primary cause of death it is probable that it contributed . The organism was typed as Salmonella Saint-Paul but the source of infection was never proved. It was thought, however, that mice may have been the cause as the patient had spent some time dealing with an infestation in outbuildings at his home and had removed mice carcases while smoking his pipe and this may have been contaminated

The two other cases occurred in January and February and were notified as food poisoning although they were never bacteriologically confirmed.

SMALLPOX: It has been recommended by the Department of Health and Social Security that vaccination against smallpox need no longer be carried out as a routine procedure in early childhood as the risk of exposure to infection is far less likely than at any previous time since the disease was first recorded in this country.

It is however emphasised that all travellers to and from areas of the world where smallpox is endemic or countries where eradication programmes are in progress, and health service staff who come into contact with patients, should be offered vaccination and re-vaccination.

RESPIRATORY INFECTIONS: 14 deaths are recorded this year from pneumonia and 3 from bronchitis and emphysema. Other respiratory infections are now seldom a cause of death, except as a terminal event, but remain a considerable cause of ill health. These are still the highest cause of loss of working hours, and bronchitis, nasal catarrh and sinus infection are still a cause of much disability.

INFECTIVE JAUNDICE: 2 cases were notified the same number as last year. Under the Health Service and Public Health Act 1968, infective jaundice has now become nationally notifiable. Acute infective jaundice is a disease caused by a virus which attacks the liver and causes jaundice. It is mainly an infection of young people, of faecal-oral spread, with an incubation period of 15-50 days. The incriminative routes of infection are from food handlers, water and children to their mothers. The virus is present in faeces 16 days before jaundice and to 8 days after. Serum hepatitis, which is another form of infective hepatitis, has a longer incubation period of 50-160 days. It affects adults mainly and can be spread by blood transfusion and inefficiently sterilised equipment used by doctors, nurses and drug addicts, and in various tattooing processes. The clinical groups of these two types of hepatitis are indistinguishable. There is no specific treatment and a jaundiced adult may be away from work for six weeks to two months, and sometimes may not feel fit for one year. Quarantine measures are of little value and patients can be treated at home or in hospital provided adequate hand-washing techniques are practised with current disinfection of excreta. Serum hepatitis can be virtually abolished if disposable equipment were generally introduced. In this county, disposable equipment is used by the County Health Department for all procedures involving immunisation. Gamma Globulin is of value for the protection of close contacts and pregnant women during epidemics.

Incidence of Infectious Diseases for 1972

Month	Scarlet Fever	Food Poisoning	Measles	Infective Hepatitis	Total
January	-	-	4	-	4
February	-	3	30	-	33
March	-	-	-	-	-
April	-	-	-	-	-
May	-	-	-	1	1
June	-	-	-	-	-
July	-	-	-	-	-
August	-	-	1	-	1
September	-	-	1	-	1
October	1	-	-	1	2
November	-	-	2	-	2
December	-	-	-	-	-
	1	3	38	2	44

Parish Incidence of Infectious Diseases

Parish	Scarlet Fever	Food Poisoning	Measles	Infective Hepatitis	Total
Barby	-	-	-	1	1
Braunston	-	-	3	-	3
Everdon	-	-	2	-	2
Kilsby	-	-	33	-	33
Staverton	-	1	-	-	1
Weedon	-	-	-	1	1
Welton	1	1	-	-	2
Woodford Halse.	-	1	-	-	1
	1	3	38	2	44

TUBERCULOSIS: Vaccination is offered against Tuberculosis by the County Council to all children at 13 years of age. This is carried out in the schools and there is a high acceptance rate.

1 new case of Pulmonary Tuberculosis, a female, was notified during the year.

CASES ON THE REGISTER AND OTHER RELEVANT DETAILS REGARDING TUBERCULOSIS FOR 1972.

	MALE		FEMALE		
	Respiratory	Other	Respiratory	Other	Total
Cases at Dec.1971	37	3	23	11	74
Fresh cases 1972	-	-	1	-	1
Cases remaining on Register Dec.1972	37	3	24	11	75

Age Group of Fresh Cases

	MALE		FEMALE		
	Respiratory	Other	Respiratory	Other	Total
65-75	-	-	1	-	1

APPENDIX

The Role of the Community Physician in the reorganised National Health Service

Community medicine is that function of medicine which concerns itself with populations, rather than with single individuals. A community is all the people living within a defined geographical area whether at home, in school, at work, or in hospital. There has been some semantic misinterpretation implying that community was separate from hospital.

In the introduction to the Standing Orders of the Faculty of Community Medicine, Royal College of Physicians (1972) the specialty is defined as "that branch of Medicine which deals with populations or groups rather than with individual patients. In the context of a national system of medical care, it, therefore, comprises those doctors who try to measure accurately the needs of the population both sick and well. It requires to bring to this study special knowledge of the principles of epidemiology, of the organisation and evaluation of medical care systems, of the medical aspects of the administration of health services, and of the techniques of health education and rehabilitation which are comprised within the field of social and preventive medicine. Community Medicine thus brings together within the one discipline those who are presently engaged in the practice of public health, in the administration of the health services whether in hospital, local authority, or central government, in relevant research, and those respensible for undergraduate and postgraduate education in the University departments of social medicine."

The reorganised National Health Service, including the new discipline of community medicine, will end the century of practice of public health as a responsibility of local government authorities.* The era was one of major progress in eliminating the gross environmental abuses to human health, and developing the personal preventive services in school health, maternal and child health. The National Health Service Act, 1948, with its deliberate tripartite structure, excluded these services allowing them to remain the responsibility of the local authorities. This decision was a compromise and permitted central government to concentrate on developing therapeutic services, particularly the building up of hospital provisions which were already crumbling and in some areas non-existent. The achievement of this latter objective has been notable. After twenty years the sharp edges of the tripartite system were becoming blurred, and the need for reorganisation was increasingly evident. These changes, many of which evolved as a result of initiative from the public health service, are now recognised and given impetus by legislation. As in 1948, the 1974 reorganisation will result in a similar (and deliberate) amalgam of compromise and concessions. While the personal health services will cease to be the responsibility of the local authorities, school and environmental health will remain with them, and arrangements will be necessary to maintain co-operation with the social services which retain many functions complementary to health.

* (The Local Government Board was created in 1871; in 1874 the office of a medical officer of health was created; and the first D.P.H. exam was held in Cambridge in 1875.)

Reorganisation of health services are timed to coincide with and relate geographically to the boundaries of local government.

The 1974 Reorganisation Structure

Central governemnt will maintain overall control with strengthened regional divisions at the Department of Health and Social Security. Finance will be centrally determined, and priorities, national standards, and objectives will be decided and resources allocated (unlike local government who first consider needs) to regions, which will largely follow, geographically, the present 14 Regional Hospital Boards. Within the regions there will be 90 Area Health Authorities co-terminus with the county and metropolitan councils of the reorganised local government. General practitioners will retain their independent status, executive councils being replaced by family practitioner committees (a part of the area structure). Central control is envisaged as tight, and regions "will co-ordinate activity and monitor performances at area to ensure that national and regional objectives are achieved."

While the structure of the reorganised health services is not considered in detail, it is useful to sketch the broad framework in which community physicians will function. Each Regional Health Authority will have a Chairman (nominated by the Secretary of State) and a committee selected for their managerial skills. At officer level, the regional team of officers will consist of a medical officer, nurse, administrator and treasurer, each with their staffs. The regional authority will be responsible for the general planning of all health services, allocation of finance at region and area, and for a number of specialist services including neuro, plastic and thoracic surgery, radiotherapy and blood transfusion, together with undergraduate teaching.

There will be 90 Area Health Authorities, each having a Chairman (nominated by the Secretary of State) and fourteen members. Areas will contain from one to five (or more) district general hospitals within their boundaries and have overall responsibility for providing all health services for the population. As stated the area will relate geographically to the boundary of the reorganised local authority. Exact co-terminosity cannot be achieved and there will be overlap areas the servicing of which is a necessary part of forward planning. The area will also be responsible for the setting up of Community Health Councils, which will serve the constituent districts and who will represent the consumer use of the National Health Service.

The area medical officer will be a member of the area team of officers, consisting of nurse, administrator and treasurer, and will have a staff of community physicians responsible for various administrative and preventive medical functions.

At both region and area Joint Liaison Committees have been established for the purpose of co-ordinating the preparatory work required prior to reorganisation, and with the responsibility of collating information, defining districts and making preliminary assessment of matters requiring decision by the shadow authorities.

General Activities of the Community Physician

Community physicians will function within these administrative units, the regional and area medical officer with their individual teams of community medicine specialists, while at district (the real operational level) there will be a district community physician, who will also be a member of a district team of officers, which will include clinicians from general practise and hospitals.

At all levels community physicians will be responsible for a wide spectrum of activities which will include planning, particularly at area and regional level; the measurement and evaluation of health programmes; the development of information systems which will include record linkage, the use of statistics, computers, morbidity and mortality indices. Planning will require rational co-ordination between hospitals and community and here assessment of priorities will be vital. In the field of preventive medicine, child health (including the school health service), health education, identification of vulnerable groups, screening, and a grasp of the effects of advances in medical knowledge will have a part, and will need skills to anticipate and deploy resources to achieve success.

Community physicians will be members of teams. This function will require new skills and success will depend on being able to convince colleagues, by the careful building up of information systems based on data, of population needs, the evaluation of existing services and the assessment of options, to accept policies and achieve agreement, then setting out successfully to implement those policies. The term 'accountability upwards and delegation downwards' if it is to work successfully will require full understanding and co-operation between officers at all levels.

The Community Physician at District Level

It is at this level that advice on environmental health to the local authorities will be required, and either the district community physician, or more likely, a designated specialist in community medicine, will act as the 'proper officer' to advise district councils on environmental health.

The health service district will be that area served by the district general hospital, involving populations varying in size from 150,000 to 300,000. Services cannot be organised on a strict geographical basis as choice of specialist will remain the prerogative of the general practitioners. Patient flows may vary with specialty. The defined boundaries enjoyed by local authorities will not therefore be applicable for health services and flexible overlap arrangements will be required.

The basic unit of the reorganised health service is the district in which primary care services supplied by family practitioners, either working in group practices, or in health centres, will be supported by the secondary specialist services based in the district general hospital. The community physician at this level will have many functions; as a member of the district medical team (the only team on which clinicians will serve); as co-ordinator of health care teams for children, the elderly, maternity, mental and mentally handicapped services, together with any other ad hoc team locally organised. He may also act as adviser to the local district councils on environmental health. He will be required to provide information and advice on all aspects of health needs and on the best deployment of resources to meet those needs.

The district will be the optimum level at which to plan and provide a substantially comprehensive service, in which the community physician will have a vital role in organising operational policies and developing district plans.

Collaboration with Local Authorities

Collaboration Committees are to be established which will include members from both local authorities and the National Health Service, with the responsibility to initiate and maintain the strongest links between the two services. Medical advice will be provided by community physicians and their staffs. Thus a major function of the community physician will be in his role as link between the local authorities and reorganised National Health Service. His success in maintaining the relationship with them will be a major factor in sustaining domiciliary services. The social services departments will retain their responsibility for the home help services, for mental health, the elderly, care of children, the handicapped and other services. The need for the strongest of ties in co-operation in planning for all these needs requires no emphasis.

School and environmental health services, including the control of infectious diseases (requiring special arrangements with district councils) should continue at their present satisfactory standards. The time honoured office of medical officer of health will cease, together with the many statutory functions, and while those already employed in the public health service are acquainted both with local authority staffing and structure and have established a relationship with its officers, unless a strong and workable system of collaboration is initiated and maintained from the outset, there could be deterioration when doctors lacking any local authority experience take their place as community physicians.

Training for Reorganisation

Immediately preceding reorganisation short courses in medical administration and integration of medical care have been set up by the Department of Health and Social Security for those already employed in administration of health services. The former, as recommended by the Working Party on Medical Administration, 1970 (Hunter Committee) are for doctors, while the latter include all those disciplines involved in health care.

Conclusions

The reorganisation of the National Health Service will mark another era in health care in the United Kingdom. The introduction of planning cycles using broad guidelines against known constraints should result in a greater sense of direction of health care planning and cohesion of all services. The opportunity will be given, for the first time, for members of the medical profession to identify what they believe to be the real health needs of the population and how they may best be met from the limited resources (money, manpower, material) available. The community physician as a member of the team at all levels will have an essential role to play. Initially his objective should be to concentrate on subjects which call for his particular expertise maintaining his present preventive activities together with the efficient collaboration with local authorities. His knowledge of statistics, epidemiology, the organisational aspects of medical care and the development of medical information systems can all provide vital components in the successful operation of the reorganised National Health Service.

THE NEW STATUTORY BODIES
RESPONSIBLE FOR NHS ADMINISTRATION

	Title	Main Functions	Method of Appointment	Account-ability.
1.	Regional Health Authorities (RHAs)	a. Regional planning and policies;	Chairman: by Secretary of State	
		b. Allocation of resources between AHAs;	Members: by Secretary of State after consultation with L.a's, universities, health professions, TUC, voluntary organisations, other interested bodies	Secretary of State
		c. Monitoring of performance of AHAs;		
		d. Executive and operational functions which need to be under-taken on a wider basis than area (inc. responsi-bility for major capital works, metropolitan county ambulance services, computer services);		
		e. Employment of medical consultants and senior registrars except in "teaching areas" (see 3 below)		
2.	Area Health Authorities (AHAs)	a. Area planning policies;	Chairman: by Secretary of State	
		b. Operation of all services (except for those referred to at 1 d.)	Members (usual pattern): local authority(ies) (statutory minimum)	RHA (except for 2e, for which accounta-bility is to the Secretary of State)
		c. Collaboration with local authorities	1 by RHA on nomi-nation of university	

	Title	Main Functions	Method of Appointment	Account-ability.
		d. Employment of staff for those purposes (except for those at 1e.)	9 by RHA after consultation with professions and interested organisations (including federations of workers or organisations)	
		e. Arrangements with family practitioners		
3.	Area Health Authorities (Teaching) (AHA(T)s)	a. As for other AHAs	As for other AHAs but with 1 or 2 additional members appointed on the nomination of universities and with additional appointments of members with teaching hosp-ital experience	As for other AHAs
		b. Provision for university of substantial clinical teaching facilities		
		c. Employment of consultants and senior registrars		
4.	Family Practitioner Committees (FPCs)	Administration of arrangements for family practitioner services	Chairman appointed by and from among members	Secretary of State
			11 members appointed by AHA (at least 1 to be a member of the AHA)	AHA
			4 members appointed by matching local authority(ies)	
			15 members appointed by the professions involved.	

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